



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 9, 2024

Licensee
In House Home Health
7336 Symphony Street Northeast
Fridley, MN 55432

RE: Project Number(s) SL36346015

Dear Licensee:

On December 27, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 19, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 19, 2023, found not corrected at the time of the December 27, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) = \$500.00

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 27, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit: **<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is fluid and cursive, with the first name "Tim" and last name "Hanna" clearly distinguishable.

Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/27/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL36346015-1 On December 26, 2023, at 1:10 p.m., the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 17, 2023. At the time of the survey, there were 3 residents: 3 receiving services under the Assisted Living license. As a result of the revisit, the following correction orders were for SL36346015-1, tag identification 790, tag identification 800, and tag identification 810.	{0 000}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living	{0 250}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance	{0 250}			

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{0 250}	Continued From page 2 relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action needed.	{0 250}			
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	{0 460}			

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{0 460}	Continued From page 3 No further action needed.	{0 460}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action needed.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

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{0 480}	Continued From page 4 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action needed.	{0 550}			
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}			

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{0 650}	Continued From page 5 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	{0 680}			

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{0 680}	Continued From page 6 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	{0 790}			

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{0 790}	Continued From page 7 This MN Requirement is not met as evidenced by: The licensee failed to provide the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 26, 2023, at 1:10 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the tour, it was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. It was also observed that each of the fire extinguishers provided was 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. On December 26, 2023, at 1:10 p.m., LALDIR-C verified maintenance had not been completed as required and the facility did not have an appropriate size fire extinguisher.	{0 790}			

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{0 790}	Continued From page 8	{0 790}			
{0 800} SS=F	TIME PERIOD FOR CORRECTION: Seven (7) days 144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 26, 2023, at 1:10 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the facility tour, survey staff observed the	{0 800}			

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{0 800}	Continued From page 9 following items: On the raised wood deck, it was observed that the area was designated as a smoking area by the posted sign but observed that the burnt used cigarettes were being disposed to without appropriate disposal container, create a possible fire hazard. In the front yard by the front entrance door, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. On the storm door from the living room to the deck, it was observed that the door closer was broken and hanging loose. And it was also observed that the glazing in the door was cracked. On the front of the building, it was observed that two out of four columns supporting the roof overhang was removed and compromised structurally. During the interview, LALDIR-C stated that the building owner purchased new posts to replace it but has not been installed. On December 26, 2023, at 1:10 p.m., LALDIR-C visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 10 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had	{0 810}			

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{0 810}	Continued From page 11 the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on December 26, 2023, at 2:00 p.m. with the Licensed Assisted Living Director in Residency (LALDIR)-C A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the available documentation and the staff training document provided by LALDIR-C contained the following discrepancies: - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will	{0 810}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 810}	Continued From page 12 automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The fire safety and evacuation plan included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. The fire safety and evacuation plan included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on December 26, 2023, at 2:00 p.m., LALDIR-C stated that the policy was a basic policy from a third-party provider and had yet to be edited or updated to fit the facility. LALDIR-C also stated that the fire safety and evacuation plan had not been modified since the original survey on October 17, 2023, and the facility was waiting on a consult to come to the facility and review the fire safety plan and evacuation procedure and update the fire safety and evacuation plan for them. LALDIR-C verified that the fire safety and evacuation plan for the	{0 810}			

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{0 810}	Continued From page 13 facility lacked these provisions. TRAINING Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire, including movement, evacuation, or relocation as required by statute. During the interview on December 26, 2023, at 2:00 p.m., LALDIR-C confirmed that the licensee provided annual training to employees, but not twice per year after the initial hire, and failed to provide the annual training to residents, on the fire safety and evacuation plan. LALDIR-C also verified that there has been no additional documented training for the staff and residents on the fire safety and evacuation plan since the original survey on October 17, 2023, and verified this deficient condition. DRILLS Record review also indicated that evacuation drills for employees had not been performed every other month as required. During the interview on December 26, 2023, at 2:00 p.m., LALDIR-C stated that the previous director provided evacuation drills last year, but evacuation drills had not been performed for the employees since he became the director. LALDIR-C also verified that no additional fire drill had been performed since the original survey on	{0 810}			

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{0 810}	Continued From page 14 October 17, 2023, and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 810}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action needed.	{01290}			
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	{01370}			

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{01370}	Continued From page 15 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action needed.	{01370}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	{01380}			

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{01380}	Continued From page 16 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action needed.	{01380}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	{01500}			

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{01500}	Continued From page 17 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	{01500}			

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{01500}	Continued From page 18 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}			

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{01530}	Continued From page 19 No further action needed.	{01530}			
{01540} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01540}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	{01620}			

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{01620}	Continued From page 20 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action needed.	{01620}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.	{01790}			

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{01790}	Continued From page 21 (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused	{01790}			

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{01790}	Continued From page 22 medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action needed.	{01790}			
{01820} SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 9, 2023

Licensee

In House Home Health

7336 Symphony Street Northeast

Fridley, MN 55432

RE: Project Number(s) SL36346015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36346015-0 On October 16, 2023, through October 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on October 17, 2023, issued for SL36346015-0, tag identification 0820. On October 19, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at level three widespread violation.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at approximately 10:00	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 a.m., licensed assisted living director in residence (LALDIR)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six (6) was electronically signed by LALDIR-C on May 29, 2022. The licensee had an assisted living license issued on September 1, 2023, with an expiration date of August 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On October 19, 2023, at approximately 10:00 a.m., registered nurse (RN)-A confirmed the licensee provided assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued: 0250, 0460, 0470, 0480, 0550, 0650, 0680, 0780, 0790, 0800, 0810, 0820, 1290, 1370, 1380, 1500, 1530, 1540, 1620, 1790, and 1820 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit;	0 460			

Minnesota Department of Health

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0 460	Continued From page 7 (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at 10:00 a.m., during the entrance conference, licensed assisted living director in residence (LALDIR)-C indicated there was no call light system in place and the residents ambulated to staff for assistance or used their personal cell phones. LALDIR-C also indicated that the house was small enough for the residents to call out for staff members when assistance was needed. On October 16, 2023, at 1:30 p.m., during a	0 460			

Minnesota Department of Health

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0 460	Continued From page 8 facility tour, the surveyor observed a split-level home with one resident located on the upper level and two residents located on the lower level. In addition, the surveyor observed no bells, call lights, or pendants. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

Minnesota Department of Health

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0 470	Continued From page 9 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required and failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 16, 2023, at approximately 10:00 a.m., the surveyor requested the licensee's staffing plan. Licensed assisted living director in residence (LALDIR)-C stated they had completed it in June and would get it to the surveyor to review. The surveyor requested to see the staffing plan multiple times throughout the survey process though it was not provided to the surveyor. The licensee's 4.06 Staffing & Scheduling policy, dated August 1, 2021 read, "1. The clinical nurse supervisor will develop and implement a written	0 470			

Minnesota Department of Health

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0 470	Continued From page 10 staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency. 3. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location. 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure." On October 16, 2023, at approximately 10:53 a.m., LALDIR-C stated they reviewed the staffing	0 470			

Minnesota Department of Health

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0 470	Continued From page 11 plan annually and they post the daily staffing schedule in the office. LALDIR-D stated, "We had one posted, but we usually keep it in the office. The office is locked but they (residents) could ask to go in and see it anytime." On October 16, 2023, at 1:30 p.m., during a facility tour, the surveyor observed the licensee lacked a daily staffing schedule posted in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 480		

Minnesota Department of Health

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0 480	Continued From page 12 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 16, 2023, for the specific Minnesota Food Code deficiencies. The inspection report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required	0 550			

Minnesota Department of Health

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0 550	Continued From page 13 information related to the grievance procedure. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at 1:30 p.m., during the facility tour, the surveyor observed the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On October 17, 2023, at 1:00 p.m., licensed assisted living director in residence (LALDIR)-C acknowledged the required content was not found on the grievance form that was available for residents, staff, and visitors. LALDIR-C would not answer any interview questions regarding this other than to acknowledge the information was missing. The licensee's Grievance policy, dated August 1, 2021, read, "A copy of the grievance procedure is conspicuously posted in the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 14 -Contact information for the state and any regional Office of Ombudsman for Long-Term-Care -Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities -Contact information for the Minnesota Adult Abuse Reporting Center." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 650	Continued From page 15 required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (registered nurse (RN)-A) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A was hired on February 16, 2021, to perform direct care services to the licensee's residents. On October 17, 2023, from at 9:34 a.m., the surveyor observed RN-A to provide cares and obtain vitals for R1. RN-A's employee record lacked an annual performance review for any years of employment with the licensee. On October 16, 2023, at 12:27 p.m., RN-A stated the surveyor had recieved all of the records and stated, "If it's not in there then I don't have it." On October 17, 2023, at 1:37 p.m., licensed assisted living director in residence (LALDIR)-C stated the surveyor was given all the records they	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
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0 650	Continued From page 16 had. LALDIR-C would not answer any interview questions regarding this other than to acknowledge the information was missing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 680	Continued From page 17 by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence of having an emergency disaster preparedness plan that contained the following required content: - establish/maintain a comprehensive emergency preparedness (EP) which describes the facility's approach to mtg health/safety/security needs of staff/residents; - address how would coordinate with other health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.); - be reviewed/updated annually; - consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - consider duration of interruptions; - consider emerging infectious diseases (EIDs); - contracts to re-establish utility services;	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 680	Continued From page 18 - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - develop and implement EP policies/procedures (P/P) based on the EP, risk assessment and communication plan; - develop/implement EP P/P to address the following whether evacuated or shelter in place for staff/residents: - food, water, medical supplies, pharmaceutical supplies; - alternate sources of energy to maintain: - temperatures to protect resident health/safety; - safe/sanitary storage of provisions; - emergency lighting; - fire detection, extinguishing, alarm systems; - sewage and waste disposal; - system to track the location of on-duty staff and sheltered residents; - develop P/P to address safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - develop P/P to shelter in place for residents, staff, and volunteers who remain in the facility; - system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policies and procedures for volunteers, including	0 680			

Minnesota Department of Health

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0 680	Continued From page 19 the process/role for integration; - development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - develop a written communication plan; - communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); - means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives - develop and maintain EP training and testing program; - participate in an annual full-scale exercise that is community based OR conduct an annual,	0 680			

Minnesota Department of Health

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0 680	Continued From page 20 individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On October 17, 2023, at 1:00 p.m. licensed assisted living director in residence (LALDIR)-C acknowledged they were missing the documentation of the above-mentioned items in the licensee's EPP and stated, "I have done some of those things, and I have told you they are done, you just need to trust that I did them." The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, read, "[Licensee's] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 780	Continued From page 21 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: The licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 780	Continued From page 22 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 16, 2023, at approximately 1:30 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the facility tour, it was observed that upon testing, the smoke alarms on the outside and in the immediate vicinity of resident sleeping room #3 and #4 was not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. This deficient condition was visually verified by LALDIR-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790			

Minnesota Department of Health

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0 790	Continued From page 23 by: The licensee failed to provide the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required for the facility . This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 16, 2023, at approximately 1:30 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the tour, it was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. It was also observed that each of the fire extinguishers provided was 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. This deficient condition was verified by LALDIR-C accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at approximately 1:30 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the facility tour, survey staff observed the following items: On the raised wood deck, it was observed that the burnt used cigarettes were being disposed to an open aluminum can with sand infill.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 800	Continued From page 25 Inappropriate disposal of cigarettes can create a possible fire hazard. In the front yard by the front entrance door, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. On the storm door from the living room to the deck, it was observed that the door closer was broken and hanging loose. And it was also observed that the glazing in the door was cracked. On the front side of the building, it was observed that one out of four columns supporting the roof overhang was removed and compromised structurally. During the interview, LALDIR-C stated that the building owner purchased a new post to replace it, and it will be installed soon. LALDIR-C visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
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0 810	Continued From page 26 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: The licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency; fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 810	Continued From page 27 in their own evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on October 18, 2023, at approximately 11:00 a.m. with the Licensed Assisted Living Director in Residency (LALDIR)-C A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the available documentation and the staff training document provided by LALDIR-C contained the following discrepancies: - The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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0 810	Continued From page 28 - The policy states that when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. During the interview, LALDIR-C stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review of the available documentation indicated that the plan did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan did include some provisions for employee action but did not include the facility-specific employee actions to be taken in the event of a fire or similar emergency. During the interview, LALDIR-C stated that the policy was a basic policy from a third-party provider and had yet to be edited or updated to fit the facility. He verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, LALDIR-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation	0 810			

Minnesota Department of Health

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0 810	Continued From page 29 indicated that the fire safety and evacuation plan did not include the facility-specific procedures for resident movement evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. During the interview, LALDIR-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALDIR-C stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, LALDIR-C verified this deficient condition and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire, including movement, evacuation, or relocation as required by statute. During the interview, LALDIR-C stated that the facility provided the resident fire safety training only when the resident moved in and verified this deficient condition. Record review also indicated that evacuation drills for employees had not been performed every other month as required. During the interview, LALDIR-C stated that the previous	0 810			

Minnesota Department of Health

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0 810	Continued From page 30 director provided evacuation drills last year, but evacuation drills had not been performed for the employees since he became the director. LALDIR-C verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents. This practice resulted in a level three violation (a	0 820	This immediate correction order identified on October 17, 2023, has had the immediacy lifted as of October 19, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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0 820	Continued From page 31 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 16, 2023, at approximately 1:30 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 34 inches in width, with a total openable area of 510 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #3 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 31.5 inches in width, with a total openable area of 472.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that unoccupied resident bedroom #2 on the main level did not have	0 820			

Minnesota Department of Health

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0 820	Continued From page 32 windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 31.5 inches in width, with a total openable area of 472.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. On October 17, 2023, at approximately 10:30 a.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALDIR)-C. During the facility tour, it was observed that occupied resident bedroom #4 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16.5 inches in height and 32 inches in width, with a total openable area of 528 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALDIR-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALDIR-C verbally confirmed the findings. On October 17, 2023, at approximately 2:30 p.m., during the phone interview, survey staff explained to LALDIR-C that an immediate correction order was issued for the above finding. LALDIR-C	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432		
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0 820	Continued From page 33 acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for two of three employees (registered nurse (RN)-A and unlicensed personnel (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01290		

Minnesota Department of Health

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01290	Continued From page 34 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-A RN-A was hired on February 16, 2021, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed RN-A to provide cares and obtain vitals for R1. RN-A's employee record contained a background study dated June 14, 2022, affiliated with the licensee's former comprehensive license under HFID 35982. RN-A's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID license 36346, effective August 1, 2021. ULP-B ULP-B was hired on August 15, 2023, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed ULP-B to provide cares to R1. ULP-B's employee record contained a background study dated August 15, 2023, affiliated with the licensee's former comprehensive license under HFID 35982. ULP-B's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID license 36346, effective August 1, 2021.	01290			

Minnesota Department of Health

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01290	Continued From page 35 On October 16, 2023, at 12:00 p.m. the surveyor and licensed assisted living director in residence (LALDIR)-C observed the NETStudy 2.0 roster and despite the licensee having requested the Department of Human Services to close the former comprehensive license, it was still open and accessible via NETStidy 2.0. LALDIR-C stated, "That is our old housing with services HFID, that license is no longer open. I went into Net study and there were two HFID numbers to pick from and I just picked the first one as I wasn't paying attention. I just did this for everyone. Mine is different because when I applied for the license, I was told I had the wrong HFID number, so I fixed mine. I will go in right away and fix everyone else's." The licensee's 4.02 Background Studies policy dated August 1, 2021, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. IN HOUSE HOME HEALTH will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01370	Continued From page 36 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01370	Continued From page 37 required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on August 15, 2023, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed ULP-B provide cares to R1. ULP-B's record lacked the following training and competency evaluations: - standby assistance techniques and how to perform them. On October 17, 2023, at 11:37 a.m., ULP-B stated, "I was trained when I was hired by [RN-A]." On October 17, 2023, at 11:45 a.m., registered nurse (RN)-A stated they thought they had completed all the required education and stated, "They go through the educare [online training platform] training and then I do training with them and then I check competencies, then they can work after that. I do review their skills within 30 days of them working as well." The licensee's 6.17 Supervision of Staff -	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01370	Continued From page 38 Delegated Services policy, dated August 1, 2021, read, "It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. Documentation of supervision activities will be retained in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all	01380			

Minnesota Department of Health

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01380	Continued From page 39 required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on August 15, 2023, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed ULP-B provide cares to R1. ULP-B's record lacked the following training and competency evaluations: - safe transfer techniques and ambulation; and - range of motioning and positioning. On October 17, 2023, at 11:37 a.m., ULP-B stated, "I was trained when I was hired by [RN-A]." On October 17, 2023, at 11:45 a.m., registered nurse (RN)-A stated they thought they had completed all the required education and stated, "They go through the educare [online training platform] training and then I do training with them and then I check competencies, then they can work after that. I do review their skills within 30 days of them working as well." The licensee's 6.17 Supervision of Staff -	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01380	Continued From page 40 Delegated Services policy, dated August 1, 2021, read, "It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. Documentation of supervision activities will be retained in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01500	Continued From page 41 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (registered nurse (RN)-A).	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01500	Continued From page 42 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A was hired on February 16, 2021, to be the the clinical nurse supervisor and to oversee and train staff and perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed RN-A to provide cares and obtain vitals for R1. RN-A's record lacked evidence annual training had been completed as required in the following areas: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living bill of rights; -Infection control techniques; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Two hours dementia training. On October 16, 2023, at 12:27 p.m., RN-A stated that the surveyor had been given all the training files the licensee had, and if they were not given	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01500	Continued From page 43 to the surveyor it was because the licensee did not have them. The licensee's 5.06 Annual Required Staff Training policy, dated August 1, 2023, read, "All staff that perform direct care services at [Licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
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01530	Continued From page 44 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure supervisors of direct care staff received the appropriate amount of initial and annual dementia care training in required topics for one of one employee (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A was hired on February 16, 2021, to be the the clinical nurse supervisor and to oversee and train staff and perform direct care services to the licensee's residents. RN-A was a full-time employee and worked Monday through Friday. RN-A's Orientation checklist indicated that RN-A would have select Dementia courses from EduCare (online training platform) library to reach 8.0 credits and subjects required. RN-A's EduCare record included six hours and	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
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01530	Continued From page 45 forty-five minutes of dementia care training completed March 14, 2021, through November 28, 2021. RN-A's employee records lacked the initial eight (8) hours of dementia care training within 120 hours, as well as the annual two hours of dementia care training required. On October 16, 2023, at 12:27 p.m., RN-A stated that the surveyor had been given all the training files the licensee had, and if they were not given to the surveyor it was because the licensee did not have them. On October 16, 2023, at 1:30 p.m., licensed assisted living director in residence (LALDIR)-C stated, "I gave you all of the employee records, that is all we have." The LALDIR-C would not answer any interview questions regarding this topic. The licensee's 5.03 Dementia Training dated August 1, 2021, read, "All staff of [Licensee] are required to complete dementia training at the time of hire and annually thereafter. Assisted Living licensed facilities: 1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 3. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. 4. A qualified trainer or supervisor must be available for consultation with new employees until training is complete. 5. Non-direct care staff will complete four (4) hours of initial training within 160 hours of the	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
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01530	Continued From page 46 employment start date. 6. All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for one of one	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01540	Continued From page 47 employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on August 15, 2023, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed ULP-B provide cares to R1. ULP-B's EduCare (online training platform) record included five hours and fifteen minutes of dementia care training completed August 15, 2023. ULP-B's employee records lacked eight hours of initial dementia care training within 160 working hours of the employment start date. On October 16, 2023, at 1:30 p.m., licensed assisted living director in residence (LALDIR)-C stated, "I gave you all of the employee records, that is all we have." When asked if all employees get assigned the same training as ULP-B and would also be missing training hours/content, LALDIR-C stated that all the ULPs get assigned the same the same training. LALDIR-C would not answer any further interview questions regarding this topic. The licensee's 5.03 Dementia Training dated August 1, 2021, read, "All staff of [Licensee] are required to complete dementia training at the time	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01540	Continued From page 48 of hire and annually thereafter. Assisted Living licensed facilities: 1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 3. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. 4. A qualified trainer or supervisor must be available for consultation with new employees until training is complete. 5. Non-direct care staff will complete four (4) hours of initial training within 160 hours of the employment start date. 6. All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01620	Continued From page 49 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of two residents (R1, R2), and the licensee failed to ensure ongoing resident reassessments did not exceed 90 days for two of two residents (R1, R2) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01620	Continued From page 50 R1 R1 was admitted to the licensee and began receiving services on February 18, 2022. R1's diagnoses included bipolar, schizoaffective disorder, anxiety, depression, hypertension, and asthma. R1's Service Plan form dated May 15, 2023, indicated R1 received assistance with dressing, grooming, bathing, medication reminders, and medication administration. On October 16, 2023, at 1:24 p.m., the surveyor observed licensed assisted living director in residence (LALDIR)-C administer oral medications to R1. R1's 14-day and ongoing 90-day reassessments titled Monitoring and Reassessment dated February 20, 2023, May 15, 2023, and August 15, 2023, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment, and indicated 92 days had passed between assessments completed May 15, 2023, and August 15, 2023. R2 R2 was admitted to the licensee and began receiving services on July 17, 2021. R2's diagnoses included multiple sclerosis and anxiety. R2's Service Plan form dated May 8, 2023, indicated R2 received assistance with dressing, grooming, bathing, medication reminders, medication administration, weekly assistance with laundry, housekeeping, and linen change.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01620	Continued From page 51 R2's ongoing 90-day reassessments titled Monitoring and Reassessment dated February 6, 2023, May 8, 2023, and August 13, 2023, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment, and indicated 92 and 97 days had passed respectively between assessments completed. On October 18, 2023, at 10:07 a.m., registered nurse (RN)-A stated, "The Monitoring and Reassessment form is what is used for all of the 14 day and 90 day assessments. I do the big assessment for the initial, but after that I just do the one reassessment form." RN-A went on to ask the surveyor what the requirements were for assessments and reassessments and stated she was unaware of all required content to be addressed in them. The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated August 1, 2021, read, "1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. 2. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 52 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. 4. For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5) as listed here: - assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing - providing standby assistance - providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication - providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises - preparing modified diets ordered by a licensed health professional a. the individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person (unless see #2), be in writing dated and signed by the registered nurse who conducted the individualized review. b. the facility will complete an individualized initial review of the resident's needs and preferences. c. The initial review must be completed within 30 calendar days of the start of services. d. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 54 provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for one of one unlicensed personnel ((ULP)-B who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
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01790	Continued From page 55 a large portion or all of the residents). The findings include: ULP-B was hired on August 15, 2023, to perform direct care services to the licensee's residents. On October 17, 2023, at 9:34 a.m., the surveyor observed ULP-B provide cares to R1. ULP-B's records lacked documentation they were trained and found competent by the RN to provide medications to residents who may have an unplanned time away from home. On October 17, 2023, at 1:11 p.m., registered nurse (RN)-A stated, "If they go out and need medications the staff can send those out if I am not here to do it, they know to check the rights and document it, but there is no form to show they were trained on it." The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, read, "For unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days with the following requirements: 1. The resident, or the resident's representative, must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances. 2. The medications must be placed in a medication container or containers appropriate to	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 56 the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. 3. The resident or resident's representative must be provided in writing the facility's contact information in case they have questions. 4. The process must be properly documented in the MAR and resident record including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01820	Continued From page 57 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on February 18, 2022. R1's diagnoses included bipolar, schizoaffective disorder, anxiety, depression, hypertension, and asthma. R1's Service Plan form dated May 15, 2023, indicated R1 received assistance with dressing, grooming, bathing, medication reminders, and medication administration. R1's Medication Administration Record (MAR), dated October 1, 2023, through October 31, 2023, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that aspirin 81 milligram (mg), carvedilol 6.25 mg, divalproex sodium 500 mg, duloxetine hydrochloride 60 mg, gabapentin 400 mg, and torsemide 20 mg was given at 8:00 a.m., October 1, 2023, through October 17, 2023. gabapentin 400 mg, lisinopril 5mg, and torsemide 20 mg was given at 1:00 p.m., October 1, 2023, through October 16, 2023. Carvedilol 6.25 mg, divalproex sodium 500 mg, gabapentin 400 mg, and quetiapine fumarate 100 mg was given at 7:00 p.m., October 1, 2023, through October 16, 2023. R1's most recent provider orders were standing orders for acetaminophen 650 mg, Maalox 30 cc,	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
NAME OF PROVIDER OR SUPPLIER IN HOUSE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 7336 SYMPHONY STREET NE FRIDLEY, MN 55432		
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01820	Continued From page 58 Imodium 2 mg, Milk of Magnesia 30 cc, Robitussin DM 2 teaspoons, Bacitracin, and A & D ointment, and were signed on February 26, 2021. The surveyor did not receive signed orders for the following medications: aspirin 81 mg, carvedilol 6.25 mg, divalproex sodium 500 mg, duloxetine hydrochloride 60 mg, gabapentin 400 mg, torsemide 20 mg, lisinopril 5mg, and quetiapine fumarate 100 mg. R2 R2 was admitted to the licensee and began receiving services on July 17, 2021. R2's diagnoses included multiple sclerosis and anxiety. R2's Service Plan form dated May 8, 2023, indicated R2 received assistance with dressing, grooming, bathing, medication reminders, medication administration, weekly assistance with laundry, housekeeping, and linen change. R2's Medication Administration Record (MAR), dated October 1, 2023, through October 31, 2023, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that R2 received Glatopa Injection 20mg per milliliter once daily October 1, 2023, through October 17, 2023. R2's records lacked signed orders for Glatopa Injection 20mg per milliliter once daily On October 18, 2023, at 9:33 a.m., registered nurse (RN)-A stated, "We looked again for doctor's orders, what you have is all we have. We	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36346	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2023
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01820	Continued From page 59 have sent them off to be reviewed and updated by the doctor, but we have not yet received them back." The licensee's 7.18 Medication & Treatment Orders - Renewal policy dated August 1, 2021, read, "Residents who receive medication management services by [Licensee] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. 1. Medication and treatment/therapy orders will be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed. 2. Medication and treatment/therapy orders will be updated with a resident's authorized prescriber following hospitalization, if any changes have occurred. 3. Signed medication and treatment order renewals will be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 10/16/23
Time: 11:20:00
Report: 103923131

Food and Beverage Establishment Inspection Report

Page 1

Location:

In House Home Health
7336 Symphony Street Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0038175
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124836326
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-700 Contaminated Food: discarded

3-701.11A **** Priority 1 ****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.
A BOTTLE OF SPOILED MILK IS HELD IN REFRIGERATOR. PERSON-IN-CHARGE DISPOSED OF ITEM. CORRECTED ON SITE.

Comply By: 10/16/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

CURRENT DISHWASHING MACHINE IS NOT ANSI/NSF APPROVED. REPLACE WITH AN NSF RESIDENTIAL GRADE DISHWASHING MACHINE, THEN USE FOR WASHING ALL DISHES.

Comply By: 10/16/23

Food and Equipment Temperatures

Process/Item: MILK

Temperature: 36F Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR

Violation Issued: No

Type: Full
Date: 10/16/23
Time: 11:20:00
Report: 103923131
In House Home Health

Food and Beverage Establishment Inspection Report

Page 2

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	1

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Tesa Brown.

The establishment has a residential kitchen and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate countertops, tile floor, painted walls and ceiling.

The kitchen finishes and surfaces are clean but show signs of wear.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

Establishment uses disposable silverware and flatware.

A residential dishwashing machine is located in the kitchen and is not of NSF Residential grade. An NSF Residential grade machine should be installed which achieves a utensil surface rinse temperature of 150 degrees F or above.

A supply of single-use gloves is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, prevention of cross-contamination during food storage, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

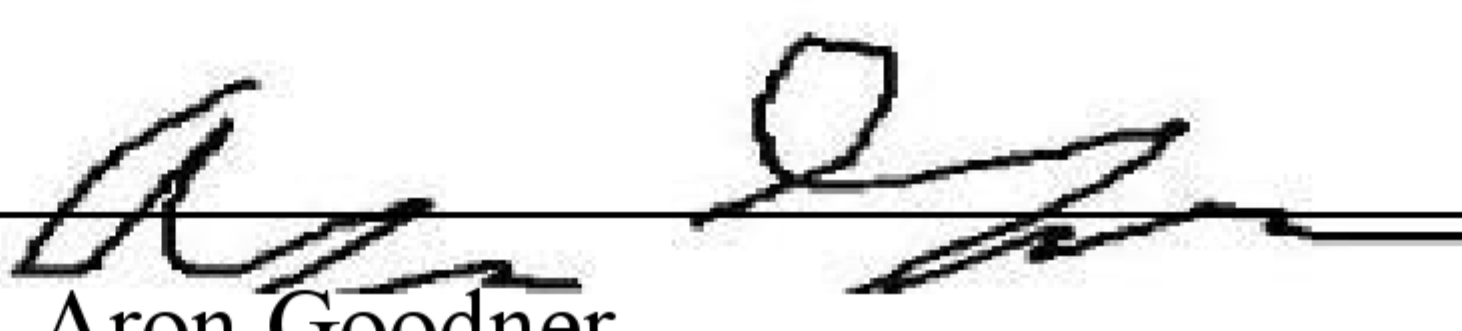
I acknowledge receipt of the Minnesota Department of Health inspection report number 103923131 of 10/16/23.

Certified Food Protection Manager Abdibasid M. Osman

Certification Number: FM108961 Expires: 11/10/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdibasid M. Osman
Person-in-charge

Signed: 
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us